# Authorization for Emergency Medical Care - Permission to Treat

| | | | |
|---|---|---|---|
| Child's Name | | Date | |
| Child's Physician's Name | | Phone | |
| Address | | | |
| Child's Dentist | | Phone | |
| Address | | | |

## Authorized Adults

Please indicate the names and contact information where you and other authorized persons can be reached.

| | | | | |
|---|---|---|---|---|
| Father's Name | Hm # | Wk # | Cell # | Other |
| Mother's Name | Hm # | Wk # | Cell # | Other |
| Other Authorized Person | Hm # | Wk # | Cell # | Other |
| Address | | | | |

## First Aid

In the event of an emergency, I authorize the staff of Early Eagle Academy to provide any first aid care deemed necessary for my child.

Parent's Signature/Date

## Emergency Care

In the event of an emergency in which I cannot be reached, the physician listed above or the local hospital are authorized to provide any emergency care deemed necessary for my child.

Parent's Signature/Date

## Health Record Transfer

In the event of an emergency, I authorized the transfer of my child's health records to the appropriate medical team.

Parent's Signature/Date

## Hospital of Choice

I would like my child to be transported to the following hospital via ambulance if needed.

Hospital Name

## Insurance Information

Insurance Company

| | |
|---|---|
| ID Number | Subscriber Name |

## Additional Instructions: Please list any allergies your child may have.